

## STATE OF VERMONT

## HUMAN SERVICES BOARD

In re ) Fair Hearing No. 15,273  
 )  
Appeal of )

## INTRODUCTION

The petitioner appeals a decision of the Office of Vermont Health Access to deny payment for an initial examination and X-rays provided to her by a chiropractor under the VHAP program. The issue is whether the petitioner was misled by the Department as to her liability for paying these costs.

## FINDINGS OF FACT

1. The petitioner is covered by the VHAP (Vermont Health Access Plan) which is administered by CHP and is overseen by the Office of Vermont Health Access. It operates for the most part under Medicaid coverage rules. As an insured member, the petitioner was provided by OVHA with a handbook regarding coverage entitled "Access Plus" with the designation beneath the title of "Community Health Plan". That handbook contained, among other provisions, the following:

The following services are available to you through the provider of your choice and do not require a referral from your CHP primary care provider:

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Chiropractic services for the spine, up to 10 visits a year.

2. Believing that the first ten visits to a

chiropractor would be paid, the petitioner, who was suffering from a wrenched neck and headaches, made an appointment to see a chiropractor in August of 1997. When she came to the office for her appointment, she showed her VHAP card to the receptionist. She had her book in her hand and asked the receptionist if ten visits per year were covered. She reports that the receptionist said yes and offered no further qualifications. She was required to and did sign a form saying she would cover any payments not made by VHAP.

3. Thereafter, the petitioner had X-rays taken and an initial exam was performed. The petitioner claims that it was only after the examination that she was told by the chiropractor that she owed \$65 for the initial exam and X-ray because VHAP only paid for the ten subsequent "treatments" and would not pay for X-rays or diagnostic exams.

4. The petitioner thereafter sought some confirmation from the Department that she was indeed liable for these expenses. She contacted CHP-Member Services on August 28, 1997, and was informed by written document dated September 10, 1997, that "Per-OVHA [Office of Vermont Health Access]--X-rays associated with chiro care covered by Vt Medicaid---Prov should bill Medicaid Depart. directly--Faxed CSF to chiro's office at member's request." The petitioner also called the VHAP division and was told by someone else in a

conversation which she tape recorded that "chiro charge for initial X-ray is not covered. Regarding initial visit-- nothing that says initial visit is not covered."

5. Although this information was contradictory and the petitioner had been told by her chiropractor that initial exams and X-rays were not covered, the petitioner went ahead and made appointments for her husband and children to have chiropractic care. She says she realized at that time that she might have trouble getting the X-rays and initial exams paid for but felt that she still had a right to rely on her interpretation of the handbook. She agreed at hearing, however, that she was only seeking reimbursement for the initial visit and X-rays which she received.

6. On September 11, 1997, at the petitioner's insistence, the chiropractor sent a request to the Department for payment of her initial exam and X-rays. The request was sent on a form usually used to notify patients that Medicaid was not being billed for a certain service. However, that form was altered to read:

I have decided to bill Medicaid for the service(s) listed below. However, the service(s) may not be covered by VHAP managed care. "X-rays and exams."

This section was signed by the chiropractor. Below that was an acknowledgement signed by the petitioner on September 22, 1997 which stated:

I understand that the services mentioned above may not be covered by VHAP managed care and that responsibility for payment is mine.

7. That claim was denied. In support of the petitioner, her chiropractor submitted a supporting note as follows:

I provided chiropractic care to [petitioner] and her family. My office staff explained to [petitioner] that Medicaid does not cover examinations nor x-rays. Coverage is limited to adjustments only. My office staff routinely informs patients of the extent of coverage. However, [petitioner] taped an interview with her insurance company stating that x-rays and exams would be covered. [Petitioner] requested that we bill for these services. The exams, x-rays, and adjustments for both Mr. and Mrs. [Petitioner] were billed as requested. We received payment on the adjustments and denials for the exams and x-rays.

The Chiropractor was not a party to this hearing nor was she subpoenaed by either party as a witness.

8. Sometime in late 1997 or early 1998, the petitioner received a new handbook from the Office of Vermont Health Access entitled "Health Care Programs Handbook" which contains the following information:

Chiropractic Services

Your program pays for up to 10 visits per year if you need treatment to put your spine back in line as it should be. More than 10 visits or services for those under age 12 need to be OK'd first by OVHA.

All services are paid by fee-for-service. You may go to any chiropractor who accepts payment from Medicaid/Dr. Dynasaur or VHAP.

9. The Office of Vermont Health Access requires providers participating in its programs, including Medicaid and VHAP, to sign an agreement as a condition for payment. Among the conditions which providers must agree to is the following:

. . .

6. To follow these guidelines regarding billing recipients:
  - If I choose not to bill Medicaid for a service, I must advise the recipient of my decision prior to providing the service. If I do not provide this advance notice, I may not bill the recipient.
  - If my reason for not billing Medicaid is that the service(s) is (are) not covered, I will provide the recipient with notice of the right to a fair hearing.
  - If I receive payment from a liable third party which is equal to or greater than the amount payable under Medicaid, I may not bill the recipient for any balance;
  - If I receive payment from a liable third party which is less than the amount payable under Medicaid, I may bill the recipient only for the lesser of any applicable co-payment, or the difference between the third party payment and the Medicaid rate. This means that if the co-payment for the service is zero, I may not collect any additional payment from the recipient;
  - If a third party payment was made to the recipient, I may bill the recipient for an amount equal to that payment;
  - I may bill the recipient for Medicaid co-payments and/or client liability (spend-down) amounts required by Medicaid regulations;
  - Other than for the circumstances listed above, I may not bill a recipient for service(s) for which Medicaid has been accepted as a source of payment.

10. The petitioner's chiropractor signed this agreement on December 10, 1996, which acknowledges that she understood "fully the standard of participation as stated on this form and will participate in the programs administered by OVHA in accordance with these standards."

11. The Director of OVHA takes the position that since the petitioner's chiropractor requested payment for the exam and X-rays and was denied, she is prevented from balance billing the petitioner under the above agreement and the petitioner is, therefore, not liable to make payments to the chiropractor. The Director has said he intends to pursue this with the provider.

ORDER

The decision of the Department not to reimburse the petitioner for the initial examination and X-rays is affirmed.

REASONS

Under rules adopted in the Medicaid program the following chiropractic services are covered:

Services furnished by a licensed chiropractor certified to meet the standard for participation in Medicare are covered.

Coverage is limited to treatment by means of manipulation of the spine and then only if such treatment is to correct a subluxation of the spine.

. . .

Medicaid does not cover an X-ray ordered solely for the purpose of demonstrating a subluxation of the spine. Any charge incurred for the chiropractic X-ray must be borne by the recipient, recipient's family, friends or such other community resources as may be available.

. . .

Coverage is limited to ten treatments per patient per calendar year.

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The petitioner does not dispute the fact that the regulations which govern coverage of chiropractic care under VHAP do not, in fact, allow coverage for X-rays or initial examinations but only for treatments which manipulate the spine. Her grievance is that the handbooks which were given to her do not contain that information and that as a consumer she was misled by that lack of information into incurring an expense for a service which she thought was being paid for by someone else.

The petitioner is, in legal terminology, making an argument that the Office of Vermont Health Access should be estopped from denying coverage of her initial examination and X-rays. The four essential elements of estoppel (relying on Burlington Fire Fighter's Ass'n v. City of Burlington, 149 Vt. 293 (1988) as set forth therein) are: (1) the party to be estopped must know the facts; (2) the party to be estopped must intend that its conduct shall be acted upon or the facts must be such that the party asserting estoppel has a right to believe it is so intended; (3) the party asserting estoppel must be ignorant of the true facts; and (4) the party asserting estoppel must detrimentally rely on the conduct of the party to be estopped. Finally, in matters which affect the public sector, a final question must be answered as to whether the injustice to the petitioner if estoppel is not invoked

outweighs any public interest in strictly applying the coverage limitations.

The Office of Vermont Health Access certainly knew what the facts were with regard to coverages available for chiropractic care. It disseminated general information with regard to those facts in handbooks for consumers. OVHA asserts that it did not put all of the details into the handbooks because it was attempting to be "user friendly" and not an exhaustive listing of all coverages. OVHA contracted with and clearly expected providers of services as set out in its agreements to provide consumers with specific coverage information before such services were provided. The information which the petitioner's chiropractor had with regard to the covered services was consistent with the regulations. The chiropractor had agreed to disseminate the specifics to the petitioner prior to the service. It cannot be said that any action taken by OVHA leading up to the provision of services to the petitioner was negligent or incorrect.

Neither can it be said that the petitioner was completely ignorant of the true facts. The information she had in the booklet on chiropractic services was very sparse.

It did not define "services" for the spine or "visits" and did not mention X-rays at all. The petitioner assumed from some very general language that everything that happened to her at the chiropractor's office during the first ten visits

was covered. If it was true, as she asserts, that no information was given to her before she received the services, it is also true that she made no inquiries as to what was not covered before she received any services.

There is no doubt that after her first visit she was aware, based on information given to her by her provider, that initial exams and X-rays were not covered. She apparently doubted that information and sought confirmation of her interpretation of the handbook as requiring blanket coverage from various persons (who were identified by name but not by position in the agency) who gave her conflicting information. It can certainly be said that by the time her husband and children started to receive services, the petitioner was not ignorant of the fact that coverage for those services was at least questionable.

Finally, the petitioner has offered no evidence that any misinformation she may have received or not received caused any detriment to her. She never said that she would not have obtained the services of a chiropractor if she had known that she would have to pay \$65 up front and out of pocket for the diagnostic services. In fact, after she knew there was a problem with payment, she brought her husband and four children in for services. She was apparently interested enough in the services to risk bearing some of the expense of their provision. It cannot be concluded that the petitioner would not have taken the course she did if

she had been better informed about coverage.

Assuming arguendo<sup>1</sup> that the petitioner did not get the specific information on coverage before the service was rendered, she has a remedy. That remedy is waiver of that fee to the provider because the provider is under a contractual agreement with OVHA to inform the patient of the specifics of coverage before the service is rendered. If the chiropractor did not do that, then she may not be able to bill OVHA or the patient for the fee. OVHA has offered to take that matter up and to make a determination regarding what happened at the chiropractor's office. As the petitioner's grievance in this appeal is against OVHA alone, no determination of liability may be made based on the criteria above and OVHA's decision not to cover those visits must be upheld as consistent with the law. 3 V.S.A. § 3091(d), Fair Hearing Rule No. 17.

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<sup>1</sup> No determination is made in this case as to whether the petitioner got the information on coverage from her provider before or after her service was rendered because the chiropractor was not a party nor witness in this proceeding and such a fact-finding could be detrimental to her interests. It is not necessary to make such a determination to decide this case as it concerns the OVHA.